United States Department of Labor
Employees' Compensation Appeals Board

S.R., Appellant	)	
	)	
and	)	**Docket No. 17-1284**
	)	**Issued: May 29, 2018**
U.S. POSTAL SERVICE, VOORHEES POST OFFICE, Voorhees, NJ, Employer	)	
	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 24, 2017 appellant, through counsel, filed a timely appeal from an April 5, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUES

The issue is whether appellant has met her burden of proof to establish more than 24 percent permanent impairment of her left lower extremity and 23 percent permanent impairment of her right lower extremity for schedule award purposes.

On appeal counsel contends that there is an unresolved conflict of medical evidence regarding whether appellant has more than 23 percent permanent impairment of each of her lower extremities, between OWCP's medical adviser and her attending physician.

FACTUAL HISTORY

On October 4, 2003 appellant, then a 51-year-old distribution clerk, filed a traumatic injury claim (Form CA-1) alleging that she developed synovitis and arthritis in both knees on October 3, 2003. Appellant attributed her bilateral knee condition to delivering a heavy parcel to a customer who lived on a hill. Appellant avoided the stairs and walked up a "90 degree driveway" and then up the remaining steps to the front door. She noted that when she reached the porch, she experienced extreme pain and pulling in both knees.

In a report dated November 4, 2003, appellant's physician, Dr. Mark A. Sobel, a Board-certified orthopedic surgeon, noted that appellant experienced chronic patellofemoral arthritis syndrome as the result of an employment injury on September 10, 1992. He reported that appellant had previously undergone left knee arthroscopy, but that she continued to experience patellofemoral arthritic pain. Dr. Sobel noted that appellant had previously received a schedule award for 24 percent permanent impairment of her left lower extremity.

By decision dated June 14, 2004, OWCP accepted appellant's claim for aggravation of synovitis in both knees.

Appellant underwent a series of arthroscopies on the right side in 2009 and 2011. Later, in 2011 she underwent a left-sided arthroscopy.

On February 1, 2011 OWCP accepted that appellant sustained a recurrence of disability on January 10, 2011 due to authorized right knee surgery.

On June 6, 2016 counsel requested a schedule award and provided a claim for a schedule award (Form CA-7) as well as supporting medical evidence.

In an April 7, 2016 report, Dr. Nicholas Diamond, an osteopath, examined appellant for schedule award purposes. He noted a history of an injury in September 1992 when appellant fell at work injuring her left knee as well as a second work injury to the left knee in 1992 when she tripped and fell. Dr. Diamond listed a March 3, 1998 work injury of lifting a tub of mail and spraining her left knee. He also described the 2003 employment injury in the present claim while

carrying a parcel.[3] Dr. Diamond noted that appellant currently had right knee swelling with no pain or instability as well as left knee pain, swelling, instability, and stiffness. Appellant's gait was symmetrical. He examined appellant's right knee and found swelling as well as range of motion from 0 through 110 degrees. Dr. Diamond found tenderness in the peripatella, medial, and joint line areas. Appellant had pain on kneeling and squatting. For the left knee, appellant had flexion and extension from 0 through 115 degrees with pain. She had effusion and peripatellar tenderness as well as pain with kneeling and squatting. Dr. Diamond reported that appellant's knee was stable to both valgus and varus stress testing with pain. On manual muscle testing Dr. Diamond reported equal 4/5 strength in the gastrocnemius and quadriceps bilaterally. He determined that appellant's right gastrocnemius was 37 centimeters in circumference, while her left was 38 centimeters. Appellant's quadriceps was 45 centimeters in circumference on the right, and 44 centimeters on the left. Dr. Diamond personally reviewed February 12, 2013 bilateral knee x-rays. Dr. Diamond diagnosed aggravation of bilateral knee chondromalacia, synovitis, and osteoarthritis, right lateral meniscal tear, and medial collateral ligament sprain, and left knee lateral meniscus tear. He also diagnosed bilateral knee compartmental degenerative joint disease and osteoarthritis with bilateral valgus deformities.

In rating right leg permanent impairment, Dr. Diamond found that under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[4] she had a class 1 right total knee arthroplasty for 25 percent impairment.[5] He applied a functional history grade modifier of 1,[6] physical examination grade modifier of 2,[7] and clinical studies grade modifier of 4[8] to the net adjustment formula of the A.M.A., *Guides* and determined that appellant had a net adjustment of plus 1 or 25 percent permanent impairment of the right lower extremity. For appellant's left leg, Dr. Diamond determined that she had left total knee arthroplasty with mild instability, 37 percent impairment,[9] with the same grade modifiers as he found on the right for a net adjustment of negative 1 and a final left lower extremity percent permanent impairment of 31 percent.[10] Dr. Diamond concluded that appellant had reached maximum medical improvement (MMI) on April 7, 2016.

[3] Dr. Diamond also described appellant's upper extremity conditions which are not addressed in this claim before the Board. The claim presently before the Board pertains only to the October 3, 2003 work injury and the lower extremities.

[4] A.M.A., *Guides* (6th ed. 2009).

[5] The appropriate class for a knee replacement under the A.M.A., *Guides* begins with a class 2 impairment. A.M.A., *Guides*, 511, Table 16-3.

[6] *Id*. at 516, Table 16-6.

[7] *Id*. at 517, Table 16-7.

[8] *Id*. at 519, Table 16-8.

[9] *Id*. at 511, Table 16-3.

[10] The Board notes that a -1 net adjustment would result in a grade B or 34 percent permanent impairment of the left lower extremity.

On June 28, 2016 OWCP's medical adviser reviewed Dr. Diamond's report and determined that appellant's left leg permanent impairment was 23 percent and her right leg permanent impairment was 23 percent. He found that appellant had reached MMI on April 7, 2016. OWCP's medical adviser disagreed with Dr. Diamond's findings, noting that Dr. Diamond did not report left knee instability prior to including this finding in his percentage of permanent impairment of the left knee. The medical adviser also discounted Dr. Diamond's finding of grade modifier 4 for clinical studies bilaterally. He determined that there were no studies completed after MMI that were specific to the diagnosis being rated. The medical adviser noted that Dr. Diamond reported that he reviewed appellant's February 12, 2013 knee x-rays, but found that he did not provide a description of the findings of those x-rays. He noted that for adjustment purposes clinical studies at MMI are used.[11] The medical adviser determined, based on the lack of details regarding clinical studies at or after MMI, that appellant's clinical studies grade modifier was not applicable. He agreed with the remainder of Dr. Diamond's calculations, but determined that based on the changes made that her net adjustment reduced from plus one to negative one in both calculations and that her left knee diagnostic class reduced from class 3 to class 2 resulting in 23 percent permanent impairment of each of her lower extremities.

By decision dated July 15, 2016, OWCP granted appellant a schedule award for 23 percent permanent impairment of each of her legs. Counsel requested an oral hearing from OWCP's Branch of Hearings and Review in a July 20, 2016 letter. In a letter dated July 22, 2016, he advised OWCP that appellant had previously received a schedule award for her left leg which he believed was 23 percent permanent impairment.

By decision dated August 16, 2016, an OWCP hearing representative determined that the case was not in posture for a hearing and remanded the claim for OWCP to determine whether appellant previously received a schedule award for her left lower extremity by recalling OWCP file numbers xxxxxx918 and xxxxxx535 and reviewing those case records to determine whether appellant previously received a schedule award for left lower extremity impairment. She instructed OWCP to issue a new decision after the additional review of appellant's records.

On September 1, 2016 counsel submitted the information regarding appellant's prior schedule awards. By decision dated July 5, 1995, in OWCP File No. xxxxxx918, an OWCP hearing representative found that appellant had previously received a schedule award for 7 percent permanent impairment of her left leg and had established that she currently had 24 percent permanent impairment of her left leg. He directed OWCP to pay appellant a schedule award for the additional 17 percent permanent impairment.

By decision dated October 18, 2016, OWCP informed appellant that the schedule award decision issued on July 15, 2016 remained unchanged and that no further action was necessary. It found that the schedule award for 24 percent permanent impairment of her left leg in OWCP File No. xxxxxx918 was issued under the fourth edition of the A.M.A., *Guides*, and that as that was a previous edition of the A.M.A., *Guides* no overpayment existed.

[11] A.M.A., *Guides* 518.

Counsel requested an oral hearing from OWCP's Branch of Hearings and Review on October 25, 2016.

By decision dated January 9, 2017, OWCP's hearing representative conducted a preliminary review, finding that the case was not in posture for a hearing. She set aside the October 18, 2016 decision and remanded the case for additional development by OWCP. The hearing representative found that on July 15, 2016 appellant received schedule award for 23 percent impairment of her bilateral lower extremities, that following appellant's request for an oral hearing, this decision was set aside and the case remanded to address evidence of a prior duplicative award. Appellant had two prior left knee injury claims[12] with schedule awards totaling 24 percent permanent impairment of her left lower extremity. The hearing representative found that, in the October 18, 2016 decision, OWCP had improperly advised appellant that there was no basis for an overpayment as the awards were paid under different editions of the A.M.A., *Guides*. She noted that the prior awards totaled more than the current schedule award for the left leg by one percent permanent impairment, and that there was no basis for finding an overpayment for the previously awarded additional one percent permanent impairment. However, the hearing representative found that appellant had been overpaid by the additional 23 percent permanent impairment she received on July 15, 2016. She directed OWCP to issue a new decision regarding the entitlement to an additional schedule award for the lower extremity and to take appropriate overpayment action.

By decision dated April 5, 2017, OWCP issued a decision granting appellant a schedule award for 23 percent permanent impairment of her right leg. It informed appellant, "This is to notify you that in accordance with the Branch of Hearings and Review decision dated January 8, 2017, which is herein incorporated by reference, this Office has amended your prior schedule award to reflect payment for only your right lower extremity. As you know, the hearing representative held that you were not entitled to an additional schedule award to your left lower extremity. Your entitlement to 23 percent permanent impairment to your right lower extremity, however, remains."

LEGAL PRECEDENT

The schedule award provisions of FECA[13] and its implementing regulations[14] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may

[12] OWCP File No. xxxxxx918 and No. xxxxxx535. As noted, these claims are not presently before the Board.

[13] 5 U.S.C. §§ 8101-8193, 8107.

[14] 20 C.F.R. § 10.404.

be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[15]

In addressing lower extremity impairments, the sixth edition requires identification of the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[17] Section 16.2a of the A.M.A., *Guides*, provides that, if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[18]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[19]

Section 8123(a) of FECA which provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination and resolve the conflict of medical evidence.[20]

ANALYSIS

The Board finds that this case is not in posture for decision as a conflict in the medical evidence has been created between the opinions of appellant's physician and OWCP's medical adviser, regarding the extent of permanent impairment of appellant's bilateral lower extremities.

The accepted condition in this case is aggravation of synovitis in both knees. Appellant had bilateral total knee replacements undergoing right knee surgery on January 10, 2011 and left knee surgery on February 16, 2012. The sixth edition of the A.M.A., *Guides* classifies the lower

[15] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[16] A.M.A., *Guides*, 521.

[17] A.M.A., *Guides*, 4, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement; *W.S.*, Docket No. 16-1111 (issued March 14, 2017).

[18] A.M.A., *Guides*, 500.

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.cf (February 2013).

[20] 5 U.S.C. §§ 8193, 8123; *B.C.*, 58 ECAB 111 (2006); *M.S.*, 58 ECAB 328 (2007).

extremity impairment by diagnosis, which is then adjusted by grade modifiers.[21] Section 16.2a includes instructions for performing an impairment analysis using the regional grids. This includes identifying a diagnosis and applying the grade modifiers.[22]

Both Dr. Diamond and OWCP's medical adviser based their impairment analysis on Table 16-3, Knee Regional Grid, of the A.M.A., *Guides*,[23] for a diagnosis of total knee arthroplasty. Dr. Diamond found that appellant had class 2 impairment of her right knee and class 3 impairment of the left knee due to instability. The medical adviser found class 2 impairments of both knees.

In his April 7, 2016 report, Dr. Diamond noted appellant's symptoms of left knee pain, swelling, instability, and stiffness and right knee swelling with no pain or instability. On physical examination he found no evidence of varus or valgus instability in either knee. Dr. Diamond found a class 1[24] right total knee arthroplasty, 25 percent permanent impairment.[25] He applied a functional history grade modifier of 1,[26] physical examination grade modifier 2,[27] and clinical studies grade modifier 4[28] to the net adjustment formula of the A.M.A., *Guides* and determined that appellant had a net adjustment of plus 1 or 25 percent permanent impairment of the right lower extremity. With regard to appellant's left lower extremity, Dr. Diamond determined that she had left total knee arthroplasty with mild instability, 37 percent permanent impairment,[29] with the same grade modifiers as he found on the right for a net adjustment of negative 1 and a final left lower extremity percent permanent impairment of 31 percent.[30]

In his June 28, 2016 report, OWCP's medical adviser disagreed with Dr. Diamond's findings noting that Dr. Diamond had not reported left knee instability prior to including this finding in his percentage of permanent impairment of the left knee. He further disagreed with Dr. Diamond's finding of grade modifier 4 for clinical studies bilaterally. The medical adviser determined that there were no studies completed after MMI that were specific to the diagnosis being rated. He noted that Dr. Diamond reported that he reviewed appellant's February 12, 2013 knee x-rays, but found that he did not provide a description of the findings of those x-rays. The

[21] A.M.A., *Guides*, 497-500.

[22] A.M.A., *Guides*, 499-500.

[23] A.M.A., *Guides*, 509-11.

[24] The appropriate class for a knee replacement under the A.M.A., *Guides* begins with a class 2 impairment. A.M.A., *Guides*, 511, Table 16-3.

[25] *Id*.

[26] A.M.A., *Guides*, 516, Table 16-6.

[27] A.M.A., *Guides*, 517, Table 16-7.

[28] A.M.A., *Guides*, 519, Table 16-8.

[29] A.M.A., *Guides*, 511, Table 16-3.

[30] *Supra* note 11.

medical adviser noted that for adjustment purposes clinical studies at MMI are used.[31] He determined based on the lack of details regarding clinical studies at or after MMI, appellant's clinical studies grade modifier was not applicable. The medical adviser agreed with the remainder of Dr. Diamond's calculations, but determined based on the changes made that her net adjustment reduced from plus one to negative one in both calculations and that her left knee diagnostic class reduced from class 3 to class 2 resulting in 23 percent permanent impairment of each of her lower extremities.

As previously noted, when there is disagreement between an OWCP physician and the employee's physician, OWCP will appoint a third physician who shall make an examination.[32] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[33] The Board finds the differing conclusions found by Dr. Diamond and OWCP's medical adviser to be of equal weight. Thus, a conflict in medical opinion evidence has been created regarding the extent of appellant's bilateral lower extremity impairments. The Board will set aside the April 5, 2017 decision and remand the case for OWCP to refer appellant to an appropriate impartial medical specialist to resolve the conflict. After such further development as it deems necessary, OWCP shall issue a *de novo* decision regarding the extent of appellant's bilateral lower extremity impairments.

CONCLUSION

The Board finds this case is not in posture for decision as a conflict in medical evidence has been created regarding the extent of appellant's bilateral lower extremity impairments.

[31] A.M.A., *Guides*, 518.

[32] *Supra* note 21.

[33] *J.J.*, Docket No. 09-0027 (issued February 10, 2009).

ORDER

IT IS HEREBY ORDERED THAT the April 5, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further proceeding consistent with this opinion of the Board.

Issued: May 29, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board